NC Mental Health Planning and Advisory Council
Meeting Minutes
Final – Approved
August 17, 2012 from 10 a.m. - 3 p.m.
630 Palmer Drive, Taylor Building, Rm #204, Dorothea Dix Campus, Raleigh, NC

Present: Marc Jacques, Mary Edwards, Kent Earnhardt, Vicki Smith, John Deir, Tricia Hahn, Gwen Belcadi (for MaryReca Todd), Gina Price, Gail Cormier, Damie Diop-Jackson , Terri Shelton (phone), Mary Lloyd (phone), Eva Eastwood, Bruce Spangler, Karen Murphy, Peter Bernadini (for Amelia Mahan), Dick Brunstetter, Sullivan, Martin Pharr.

Staff Present: Maria Fernandez, Adult Planner, Susan E. Robinson, Child Planner

Others Present: Brenda Piper, Angela Harper, Ken Edminister, Adolph Simmons, Lee Lewis, Walt Caison, Emery Cowan, Patsy Coleman, Planner for the Substance Abuse Prevention & Treatment Block Grant

Welcome, Introductions, Review Minutes & Agenda
Marc Jacques, Chair, convened the Council meeting. Introductions were made and welcomes were extended. The handouts distributed included, the meeting agenda and prior meeting minutes for review and approval. Minutes reviewed and approved as amended. The agenda was reviewed with minor time modifications.

SAMHSA/CMHS Grantees Meeting July 30-Aug 1

- A report by those who attended the federal block grant grantees meeting in Maryland. Marc represented the Council, Maria (Ging) Fernandez, Walt Caison and Patsy Coleman participated from the division of MHDDSAS. Marc reported he was glad to attend and thought there was a lot of energy and synergy. This was especially true regarding topics discussed with the intention for implementing best practices and recovery housing session. He noted particular the techniques that other states are implementing. Recovery housing as an example was presented and this addresses both MH/SA along the Atlantic coast. He stated there are ways to implement this in NC.
- Ging reported that there was a Government Accounting Office (GAO) report on services provided.
- Walt was inspired before going to the meeting, found that the meeting provided some good information to consider, though expected more dynamic exchanges offered from the speakers and presenters.

Proposed Block Grant Changes by CMHS/SAMHSA
Some of the highlights include the following. <u>The changes assume that</u>:

- block grant funds will be used to help provide services and supports to adults or children/youth with serious mental health treatment needs who will not have services through the health services act (Affordable Care Act – ACA.)
- Health reform will be in place.

- System of Care (SOC) is referenced as a framework for service delivery and care coordination.
- Timeframes will change for the block grant to a state fiscal year; it is currently on a state fiscal year.
- Timeframes and process for preparing future plans, beginning with SFY2014 Plan will occur, with a plan to be submitted in April for June approval and July 1 implementation. (None of the details are worked out about this as these are proposed changes at this point in time.)
- Children and youth will be included in the plan, though little is stated about this.

Discussion:

- Gail Cormier stated North Carolina's plan and council process is very inclusive and gives priority to children. She indicated we should be very proud of how NC uses the MHBG dollars and how the Council is involved in developing the plan, reviewing the data, writing the measures and targets. This is not the case in other states. In other states, the Council is the only place where consumers and families have a voice in policy. This is also not the case in NC, where there are many tables and levels where involvement and partnering happens.
- Gail stated that she and other family organizations have serious concerns about the degree to which children and youth are left out of the language in the block grant changes. As proposed, the priority to help address the needs of children and youth through the block grant could be lost entirely. This would undermine the work of child advocates and certainly add to the costs to states in lives lost, imprisoned, uneducated because of lack of treatment and address to mental health needs early in a child's life when effects can be mediated.
- John stated that he also has concerns regarding the direction of CMHS re: children and youth given the significant needs we see in NC for more services and supports. He encouraged the Council to keep children and families a priority regardless of federal direction.
- Marc suggested that NC's leadership and opportunities to engage youth was seen recently through the art exhibits and stigma slam among other ways youth voice is present in NC and supported by the block grant funds.

Additional discussion on potential block grant activities included the following:

- Kent asked if there are anti-stigma programs in place or could this be considered, especially now in light of the rising need for education of the media and community education regarding people with mental illness. Kent referenced the recent lack of appropriate information and poor statements made in light of the recent shootings that have occurred by an individual who chose to not seek needed treatment.

- Walt agreed with Kent especially as we work to help individuals live in communities of their choice and reintegrate in the community. This is one of the division's and advocate's

persistent challenges of NIMBY –not in my backyard. Ill-informed media often make poorly informed statements and perpetuate unnecessary stigma.

- Marc suggested that *In Our Own Voice,* a NAMI strengths based process to support individuals in telling one's story is an excellent tool to help with this. Marc suggested that it would be very easy to incorporate stigma positive messaging as panelists and in one's story.
- Damie indicated that the youth/young adults have been very concerned about stigma and living in the community. NC Youth MOVE received a national Youth MOVE award – the best youth organization in the nation. Damie stated that the national group is looking to NC's youth work in this arena. Members congratulated NC Youth MOVE for being given this award.
- Kent indicated that there is a state by state policy re: victims and we might want to look at NC's harm reduction efforts and how victims are assisted.
- Marc stated the issue is one for the Council to consider in setting priorities.

SFY 2013 MHBG Plan Application Update

- There was a one-time $9 M reduction in SAPTBG $9 M that was recently imposed by the NC DMHDDSAS. This reduction was necessary to adjust allocation procedures that had been in place over time. Staff reviewed this reduction with the Council and the details of the LME director communication sent out on July 3, 2012.

Discussion:

- Members were concerned that such a significant cut is reducing substance abuse treatment services significantly, with loss of programs and expert staff in communities where such treatment is needed for progress toward recovery. Concern for rebuilding that which is lost through these cuts will be very difficult.
- The Council stated this was an absurd cut in treatment when the people's needs for treatment keeps growing; this is a large concern.
- The impact will be affected locally – programs are having a hard time in knowing how to actualize the reductions, changing benefit plans in either group vs. individual treatment or limiting the length of stay for treatment services-which may not be ideal or evidenced informed.
- Members were concerned that this would affect the treatment facilities. Staff stated that the reduction did not affect these facilities.
- Members suggested that the facilities need to be linked to the LME cost-benefit. For the state facilities, the MCOs would have the cost of the Medicaid; with cost-shifting to the state facilities. The example offered was regarding Wakebrook who is building 42 beds – building the top of the pyramid instead of the foundation under it for services and diversion for community based treatment services
- It was suggested that as managed care is implemented this will change re: facility cost-shifting. Another member wondered if this was the system's chronic subliminal failure.

- Concern was expressed for state facilities experiencing significant cuts. An example offered of a young person with a gun, with recycling hospitalizations every 3 days with no access to a state hospital bed. There is a difference between taking beds away from state hospitals and investing in community services.
- It was agreed that days of treatment is not the best measure for substance abuse treatment, but indeed days/time of length of service is important to measure.
- It was also agreed by members that in setting the measures when shifting to another model, we need to keep the prevention services in mind another model and in the "ask" when treatment or potential settlement is discussed. We must get ahead of the curve of the high need we are seeing and intervene earlier.
- Members encouraged division leadership to seek consumer perspective and input when setting measures and outcomes so that prevention and intervening early is a part of the change effected every time more treatment funds are sought.

Council Priority Planning for SFY 2013 & SFY2012-2013 Plan Framework

- In light of the prior discussions, members indicated that the Plan we submitted does not reflect the crisis and alarm to the needs we have in our state.

- Members want to be sure these concerns are addressed. In considering what the state needs to address such concerns. It was agreed that the state lacks and needs a clearly articulated policy to achieve this.

- Members considered the other questions including, how do we make connections? and how do we address the path to getting the outcomes? In so doing, the Council drafted a table *Making the Connections* (attached) that contained priority focus for SFY2013 and considered additional questions and potential resources to seek, technical assistance needed, and steps to take.

<u>For Recovery Supports for adults the following were suggested:</u>

-- NC NEEDs the HOW – mechanisms for connecting certified peer supports
– promote volunteering that begins to build paid positions
– set up matching funds for establishing support as a mechanism
– in the absence of the opportunity for paid position
– a method to validate who is certified, how they are supervised and coached and who is an active practitioner
– UNC- CH has the data base for jobs and for those who have been trained
-- Analogy – built schools and community services, women worked in factories, others – AA in factories – recovery – EAP – employee assistance jobs began in that era

For Building Resilience and Family Partners the following were suggested:

- More than 220 trained family partners – a majority already are volunteers and volunteer time- this is not the answer for children and families

- Results from those Family Partners who are certified and paid, are better than those who volunteer. There is an assurance and commitment by the agency who engage Family Partners that they will supervise, coach and support as part of the team. Investment makes a difference in the outcome. Studies for B-5 year old system in Alamance will help show such an effect even with young children and families where Family Partners are involved.
- It is a slippery slope for those who volunteer vs. certified and paid; issues are related to "not instead of paying" and "instead of Value added"
- Family Partners do not want to "assume" volunteer, in doing so, will never be honored and paid for the hours of training, time and costs associated (includes motivational interviewing, evidenced informed practice training, etc.

-Promote HOW helping one another is a part of healing.

Time bank system is an alternative for peer supports/family partners e.g. First in Families, Alamance SOC with NCFU to establish a time bank

Members agreed to narrow the focus for SFY 2013 in response to Marc's question of "What do we want to do? " There was uniform agreement that the following are priorities the Council recommends the division focus on:

- Peer Support – identify ways in which both paid/non-paid positions can be established and supervised
- Establish work incentives (e.g. establish service definitions with reasonable rates of reimbursement for services; change ways job applications ask – where do you work – volunteer/paid)
- Family Partners – increase funding to leverage additional paid Family Partners working with SOC Coordinators and MCOs.

An outline of the Council's priority focus is the the Table attached, *Making Connections*.

Next Steps for the Council Related to Priorities Identified:

- A motion was proposed for the Council to consider: The Council will recommend that the Division and DMA require by performance contract that: Each LME/MCO will be required to use MHBG funds to have 1 FTE fully nationally certified family partner and 1 FTE certified peer support specialists who have meaningful input into the LME/MCO policies.

The motion was proposed by John, seconded by Gail; discussion ensued, the question was called and vote taken, 4 in favor, 1 opposed, 5 abstained. This motion did not carry. A statement of appreciation for everyone's consideration was made. Members were encouraged to take action on important discussion regarding priorities given the amount of time spent on the topics, 'it is time to put feet into action.'

Some members expressed interest in learning more about volunteer models. It was suggested that in the first meeting in SFY2013, the Council review and study models of volunteerism to develop a mechanism for increasing access to and implementing certified peer support specialists in the MHDDSA service system. Other members asked that service definition for family partners be considered as a viable billable service through Medicaid following other state practice models. Council staff will pursue this information and plan accordingly for the first meeting in SFY 2013.

Related Discussion:

- A question was raised regarding whether this was duplication to what is now required for LME/MCO Board members – 3 must be consumers?
- LME/MCOs finally agreed to keep the original legislation to keep SOC Coordinators and their functions in place
- John stated a major concern for children's services is how it will be possible for SOC to continue to have impact without family voices being at the table and working in partnership with family partners/SOC Coordinators. They are becoming more systems level vs. directly impacting and working with families. This is a significant change.
- The LME/ MCOs are more concerned that business drives function and then form.
- Gail stated that such a little amount of block grant funding has been able to leverage more for families and children than could be imagined. When she began work in NC, there were 6 family partners, now there are more than 220 fully trained family partners working with families across the state. This is important and needs to be recognized.

Update on Adult focused Division Priorities:

Emery Cowan, Best Practice Team provided an update on the following:

1) Adult care homes (pending DOJ resolution) – what services exist such as ACT, CST, supported employment
    - A survey will be completed with the LMEs and providers

        A work group has been formed and will meet next week to discuss service definitions, national evidenced based practices (EBPs) – Dartmouth model and looking at fidelity scales for practice implementation.

2) supported employment initiative –

- Looking at the Dartmouth model of IPS – Individual Placement & Support – supported employment – VR/all disabilities
- $18M – ADVP – DMH pays all state dollars for this service – we can use more wisely and need to examine.
- $2.2M – supported employment – Employment First (expectation not exception to work)
- Rapid employment not employment readiness
- Challenges for youth/young adults to be engaged with VR –how can youth access to supports – we must look at models that work and implement in NC with DVR. Too many youth feel 'closed out' of VR when they are eligible for assistance, esp. those who may have a substance use disorder (SUD.) are eligible for assistance though are often turned away because even though they may be in substance abuse treatment, they may still be using/abusing substances and VR deems them ineligible.
- Gina indicated that when combined in VR, 52% of resources are for MH/SA
- Emery stated that the division and VR must meet a goal of serving 100 individuals in 2013, serve 2,500 by 2019; for those who have been served thru DMH thru supported employment – many will include VR numbers.

- ACT teams – revamping this service definition will occur – need to implement fidelity n NC, we have too many ACT teams relative to the size of the state vs. other states such as Florida who have fewer statewide for a larger population. In 2009, 106 ACT teams billed for $38M; in 2010 162 ACT teams billed for $??M

- VR among other service agencies, schools, etc, don't seem to know how to work with and engage youth well, esp. in Futures planning and how the youth's plan is embraced and their goals (i.e. self-run business that is encouraged and embraced in work plans.) NEED to help organize, coordinate and train across systems for a better understanding in order to improve youth/young adult outcomes.
- Damie stated that VR counselors need to accept the Futures Plan. Gina suggested that Damie talk with Alice Farrar, the new child/youth VR contact. Gina agreed there are challenges with policy that act as a barrier to access for those who are eligible.
- Client assistance program – more information needs to be provided about VR client appeals, this will help also.

Division Updates

Waiver Implementation

- Vince Newton , LME Best Practice Team and liaison to Smoky MCO, presented an overview refresher of the waiver components, rationale, and a summary of how Smoky has gone about implementing the waiver as a new MCO. Each MCO has various challenges and strengths in the implementation process. In particular, Vince stated that Smoky has

included consumer advisors every step of the way, the local CFAC members are very involved and that providers and community agency partners have been very positive about the change process and accessibility experienced to date during initial stage of implementation.

Next Meeting is on November 2, 2012

From today's planning and discussion, the proposed meeting agenda includes the following for November 2, 2012.

- SFY2011 MHBG Report - data trends and targets (met/not & why), accomplishments, challenges, significant achievements for the year, Council recommendations and priorities (these will help set the agenda for 2013 meetings)
- family partner and youth leadership development update
- peer support update
- DOJ update
- Brad Trotter, Deaf Services coordinator has asked for 45 min;
- Debbie Webster on homeless and aging initiatives - 20 min update;
- waiver implementation update, and
- new information on:
- the DOJ settlement;
- the 5 DHHS priorities, including the PRTF children's effort underway to bring the Council up to date

Meeting Adjourned

Members were thanked for their active participation and dialogue. Meeting was adjourned.